Briefing

THE HEALTH AND SOCIAL CARE BILL: REPORT STAGE IN THE HOUSE OF LORDS SERVICE RECONFIGURATIONS AND THE FAILURE REGIME

This briefing focuses on the implications of the Health and Social Care Bill for service reconfigurations and for the failure regime for providers that are financially unsustainable. It draws on the debates on these issues during the Bill's Committee stage in the House of Lords and a number of recent reports and briefings we have published on these subjects.

Reconfiguring hospital services

In the long term, demographic change and the shifting burden of disease require a fundamental shift away from acute care in hospitals to supporting people with long-term conditions in the community. More immediately, financial pressures, shortages among some parts of the workforce and the need to improve quality and safety mean that changes to hospital services in some parts of the country are already a necessity, not an option. As the Health Select Committee's recent report on public expenditure emphasised, fundamental changes to services are essential to meet the Nicholson Challenge (Health Select Committee 2010).

There is also emerging evidence that for some services like stroke, trauma and children's heart surgery, concentrating specialist expertise and equipment in fewer centres of excellence leads to better survival and recovery rates. For example, early findings suggest that the reorganisation of stroke care into fewer specialist units in London is resulting in lower mortality rates. The need to reorganise specialist services is particularly acute in London, Manchester and the major conurbations, where there is widespread recognition that the current pattern of hospital provision is unsustainable.

Our recent report on improving health care in London highlighted the significant problems facing the NHS in the capital and the risk that there will be a lack of strategic leadership following the abolition of the strategic health authority in April 2013 (Appleby *et al* 2011). Based on analysis subsequently published by NHS London (NHS London 2010), the report found that even on an optimistic assessment, only 6 of 18 NHS acute trusts in the capital are likely to be financially viable by the 2014 deadline for achieving foundation trust status.

Ministers have argued that service change should be locally led. During Committee, Lord Howe stated 'we should be cautious about any process that would significantly weaken both local commissioner autonomy and public engagement' (Hansard 13 December col 1271). We agree that clinicians and local communities must be fully engaged in the process of service change. However, local involvement and strategic leadership are not mutually exclusive. For example, the reorganisation of stroke services in London proceeded with strong support from clinicians and the public. Critically though, the process was led by the strategic health authority, which was able to lead change across the capital based on the plans set out in the Healthcare for London report (NHS London 2007).

With the abolition of strategic health authorities from April 2013, it is not clear how strategic reconfigurations of specialist services will be led. Despite ministerial assertions to the contrary, it seems unlikely that clinical commissioning groups will have the appetite or capability to lead complex service reconfigurations across wide geographical areas. As the Health Select Committee report pointed out, despite the emphasis on

service redesign in national policy guidance, 'local reality does not reflect the national policy objectives'. Clinical senates could have an important part to play, but their role is as yet unclear and is likely to be confined to providing clinical advice, rather than leading and implementing the process of change (see below).

In Committee, Lord Howe stressed that the NHS Commissioning Board 'will be able to support clinical commissioning groups by providing support and advising on the possible effects of larger changes' (Hansard 22 November). A recently released paper outlining the design of the NHS Commissioning Board confirmed that 'involvement in large scale reconfigurations' will be one of the functions of the four regional sectors that will be established as part of the Board (NHS Commissioning Board 2010). However, with thousands of posts being stripped out of commissioning structures to meet the government's target of delivering a 50 per cent cut in management costs, each sector will employ only 50 staff and will have responsibility for a number of other key functions. As a result, there is a serious risk that the new sector offices will lack the experience and capacity to initiate and manage the scale of change needed in many parts of the country.

The lack of clear responsibility for driving forward strategic reconfigurations of services is the most significant omission from the Bill. Ministers must provide a clearer explanation about how these reconfigurations will be taken forward under the new arrangements – otherwise the risk is that the NHS will not be equipped to meet one of the biggest challenges it faces over the next few years.

The failure regime

The alternative to a commissioner-led process is to leave the reconfiguration of services to the market. This appears to be the government's preferred approach despite experience in South East London and elsewhere which suggests that market forces alone will not drive reconfigurations of services that benefit patients (Palmer 2011).

Initially, the Bill proposed a failure regime for providers that are financially unsustainable based on insolvency procedures, with a process led by Monitor for designating 'essential' services ex post that would be protected to ensure continuity of service in the event of financial failure. However, the government tabled a series of amendments at Report stage in the House of Commons to replace this with a modified version of the current failure regime set out in the Health Act 2009. Under the revised arrangements in the Bill:

- Monitor will be responsible for intervening to support providers when they are in financial distress but have not yet reached crisis point by, for example, using turnaround teams or replacing the incumbent management
- once it becomes clear that a provider is not financially sustainable, a trust special administrator will be appointed to take over the failing service and draw up an administration plan
- at this point, commissioners will be responsible for identifying services that should be protected in order to secure continuity of access for the public
- Monitor will be given powers to levy a charge on providers and commissioners to create a standing fund to cover the costs of administration and maintaining access to essential services when providers fail
- the Bill also removes the power to 'de-authorise' foundation trusts and place them under ministerial control.

These provisions were inserted into the Bill towards the end of its passage through the House of Commons and have so far received little parliamentary scrutiny. We support the aim of striking a more effective balance between maintaining access to essential services and avoiding subsidising inefficient or poor-quality providers, and agree that the power to de-authorise foundation trusts should be removed. However, there are deficiencies in the provisions outlined in the Bill that need addressing to provide an effective failure regime and, in particular, to encourage the planned reconfiguration of services before more drastic action is needed.

Financial distress might arise for a number of reasons: poor management, inherently high costs specific to the provider's circumstances (for example, if it is located in a remote rural area) or wider problems within the local health economy. Our concern with the Bill as it currently stands is that, while it provides the basis for an effective regime where financial distress can be attributed to poor management (through intervention by Monitor) or high costs due to the provider's circumstances (in which case a higher tariff may be sanctioned for essential services), it is not designed to respond to problems in the wider local health economy.

In these circumstances – as we highlighted in a report last year based on the experience in South East London – relying on market forces or local commissioners to drive change may not be sufficient (Palmer 2011). The report was based on a detailed analysis of protracted efforts to reorganise services in South East London, where financial problems and concerns about patient care had plagued four of its six local hospitals for a number of years. It showed that commissioners had been either unwilling or unable to tackle the problems facing the local health economy and that it was only when the strategic health authority became involved that progress was made. In the meantime, A&E and maternity services at Queen Mary's Hospital in Sidcup were forced to close on safety grounds.

This example highlights the importance of commissioners and providers working together to reconfigure services before crisis point is reached. However, it also underlines the difficulties outlined above that market forces alone will not drive reconfigurations in the interests of patients and that clinical commissioning groups are unlikely to be able to oversee complex reorganisations of services across wide geographical areas. The Bill does provide for Monitor to initiate a 'planning process' during the distress phase. However, little detail has been provided about how this will be triggered, and Monitor's focus will be on individual institutions, not the wider health economy.

It is essential that commissioners and providers work together to reconfigure services in the distress phase, before the failure regime is invoked. Given current experience, the government must provide more clarity about how this process will be triggered and how service reconfigurations will be taken forward across local health economies.

Alongside this, a number other improvements should be made to the regime set out in the Bill.

Support for commissioners

It is vital that commissioners have access to up-to-date intelligence about the financial circumstances of local providers and to specialist clinical advice. Clinical senates could provide the latter but it is not yet clear how their role will be defined.

- **Monitor should be under a duty to provide financial information about providers to clinical commissioning groups and the sector offices of the NHS Commissioning Board.**
- **The role of clinical senates and how they will support service configurations requires clarification.**

Improving the reconfiguration process

The current process for reconfiguring services is often protracted and expensive. For example, the reconfiguration of hospitals in South East London took more than six years and, as set out above, some services at Queen Mary's Hospital had to be closed before the plans were approved. To prevent problems escalating and avoid the frequent use of the failure regime, it is vital that plans for reconfiguring services are drawn up and agreed as quickly as possible.

- **A regulation-making power should be included in the Bill to enable maximum timescales to be set in secondary legislation for how long each stage of the reconfiguration process should take. This should include time**

limits for proposals to be considered by local authority overview and scrutiny committees and for decisions by the Secretary of State.

Local authority overview and scrutiny committees can currently refer proposals 'not in the best interest' of local communities to the Secretary of State. In our view, referrals to the Secretary of State should be the exception not the rule, and should focus on whether public and patient engagement has been sufficient rather than substance of the proposals.

- **The basis on which referrals are made to the Secretary of State should be tightened up.**

Defining essential services

Under the revised failure regime now set out in the Bill, commissioners will be responsible for identifying essential services that should be protected in order to maintain continuity of access for the public. However, no definition of 'essential' is provided and only limited evidence exists about the link between access to services and health outcomes to support commissioners in making these judgements. With the Bill proposing to subsidise essential services in these circumstances through a levy on commissioners and providers (see below), guidance is needed to support clinical commissioning groups in making these decisions and ensure consistency, especially in areas such as maternity and emergency care where these judgements are most difficult to make.

- **A regulation-making power should be included in the Bill for the Secretary of State to issue guidance on how clinical commissioning groups should define essential services.**

The levy on commissioners and providers

The Bill empowers Monitor to levy providers and commissioners in order to build up a risk pool to draw on to maintain essential services. We support the establishment of a transparent funding mechanism for securing essential services when providers go into administration. As Lord Howe pointed out in Committee, it is important to create incentives for providers to manage financial risk (Hansard 13 December col 1257). However, we are less clear how the proposed levy will incentivise commissioners to work with providers to reconfigure services at risk of financial failure.

- **Ministers should clarify the justification for placing a levy on commissioners as well as providers. Regulations should also ensure that the size and distribution of levies by Monitor create incentives for providers and commissioners to work together to prevent failure.**

Transitional funding

The Bill currently provides for Monitor to agree a variation to the national tariff where this can be justified, for example, because of unavoidable costs of operating in a particular location. However, it is not clear whether this mechanism can also be used to provide transitional funding in the form of a tapered subsidy for providers who need time to make structural adjustments to prevent them becoming financially unsustainable.

- **Ministers should clarify whether transitional funding is permitted where this is needed to ease the transition to the new transparent financial regime and to support providers in restructuring services.**

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